Flathead County Functional Needs Registry for Individuals

The Functional Needs Registry for Individuals is a database containing information about individuals residing in the Flathead County who may require assistance in the event of an emergency. This registration website allows residents with specific needs an opportunity to provide information to emergency response agencies so those agencies can better plan to serve them in a disaster or other emergencies.

The Functional Needs Emergency Registry is for residents with disabilities, chronic conditions, and other healthcare needs such as: use of oxygen, respirator/ventilator, dialysis, pacemaker, defibrillator, or insulin-dependence; use of a wheelchair, walker/cane, prosthesis, or an assistance animal; visually impaired, legally blind, hard of hearing, deaf, speech impaired, non-verbal, or cognitively/developmentally delayed. **This registry is completely voluntary, and all information obtained through this registry follows all HIPPA laws and regulations for privacy issues.**

To be considered a "Functional Needs" citizen in Flathead County, you must be able to classify yourself into one of the following categories:

- Visually Impaired
- Hearing Impaired or Deaf
- Mobility Impaired
- Developmental Disability
- Mental Illness
- Anyone with a medical condition requiring human, mechanical or service animal assistance to accomplish the activities of daily living, to receive medication or treatment or as a part of a medical monitoring program
- Non-English speaking
- Low Literacy
- Anyone without transportation to a safe destination
- Seniors with disabilities and functional needs
- Isolated populations

Once Flathead County Health Department or Emergency Services receives your registration, it will be reviewed to make sure the classification of "Functional Needs" is met.

There is no substitute for personal preparation. In a disaster, government and other agencies may not be able to meet your needs. It is important for all residents to make individual plans and preparations for their care and safety in an emergency.

The information collected here will not be available to the public. It will only be shared with emergency response, human service, and public health agencies to improve their ability to serve those in need.

Please be as complete as possible in your responses. If you have any questions, please contact us.

By submitting your information, you agree that you voluntarily authorize its release.

The process is simple:

- Citizens in Flathead County fill out the Functional Needs Registry Form
- **Please print clearly and provide all information.**
- **Please update your information annually**

To register please download and send us the registration form or submit your information on-line where it will be validated.

Flathead County Functional Needs Registry Form

Disclaimer

The purpose of the Flathead County Functional Needs Registry is to provide emergency responders in Flathead County with important information from individuals that may require assistance during an emergency, such as tornado, flood, blizzard, and power outage or disease outbreak. **This program is voluntary and in no way ensures that the individual completing this form will receive immediate or preferential treatment in an emergency.** This program will merely provide the emergency response community with information that is pertinent to developing an effective response. The Flathead County Functional Needs Registry in no way replaces the responsibility of individuals to have their own emergency plan.

Filling out this form is strictly voluntary and the data will be kept strictly confidential. It will be available only to local emergency assistance officials. **Please print clearly and provide all information.**

Personal Information

Date	❑ New Registration ❑ Update of Existing Registration				
Last Name	First Name		MI	Date of Birth	Sex
Street Address	City	Zip	Home Phone	Cell Phone	
Home Phone	Cell Phone	Message Phone	Do you use TDD ❑ Yes ❑ No		
Email address					
Primary Language	Understand English ❑ Yes ❑ No Read English ❑ Yes ❑ No Write English ❑ Yes ❑ No				
Name of Subdivision, Mobile Home Park, Apartment Building, etc.					

Living Situation ❑ Live Alone ❑ With Spouse ❑ With Children ❑ With Parents

❑ Group Hone ❑ Other (Explain) _____

Type of Residence ❑ House ❑ Mobile Home ❑ Apartment ❑ Assisted Living Facility

❑ Senior Housing Complex/Facility ❑Homeless ❑ Shelter

Is there an elevator for use at residence ❑ Yes ❑ No

Winter Resident Only ❑ Yes ❑ No Summer Resident Only ❑ Yes ❑ No

In total, how many people live in your household _____

Emergency Plans

Do you have an emergency plan to ensure your safety during different types of emergencies ❑ Yes ❑ No

Do you have emergency supplies on hand to last up to 3 days ❑ Yes ❑ No

Do you have access to information and communication devices that would notify you of an emergency? ❑ Yes ❑ No

Do you have out of town contacts? ❑ Yes ❑ No

Do you have a backup up power supply for essential medical equipment? ❑ Yes ❑ No

If evacuation is required do you plan to:

Evacuate to a public shelter ❑ Yes ❑ No

Evacuate to home of family/friends ❑ Yes ❑ No

Evacuate to another location ❑ Yes ❑ No Please specify _____

What are your personal needs, and resources available to meet those needs, in the event of an emergency?

Needs	**Resources**

Type of Functional Need

❑ Hearing Impaired ⇨ Communication Assistance Needed ❑ Yes ❑ No

❑ Visually Impaired ⇨ Guidance Assistance Needed ❑ Yes ❑ No

❑ Speech Impaired ⇨ Communication Assistance Needed ❑ Yes ❑ No

❑ Physical Impairment ⇨ Mobility Assistance Needed ❑ Yes ❑ No

❑ Developmental Disability

❑ Mental Illness

❑ Non-English speaking

❑ Low Literacy

❑ Without transportation to a safe destination

❑ Isolated populations

❑ Homeless

Medical Information (Check all that apply to your condition)

- ❑ Advanced Alzheimer's Disease
- ❑ Advanced Dementia
- ❑ Allergies (Please Specify)

  _____
- ❑ Anxiety or Depression
- ❑ Assistance with Bathing
- ❑ Assistance with Dressing
- ❑ Assistance with Use of a Toilet
- ❑ Autism
- ❑ Bladder Dysfunction
- ❑ Bowel Dysfunction
- ❑ Catheter
- ❑ Chemotherapy
- ❑ Colostomy
- ❑ Conduct Disorder
- ❑ G or J Tube Feeding
- ❑ Hospice Care
- ❑ Insulin (Refrigerated)
- ❑ Insulin (Non-refrigerated)
- ❑ IV Therapy
- ❑ Medication Management
- ❑ Suctioning
- ❑ Tracheotomy Tube
- ❑ Unstable Cardiac Condition
- ❑ Unstable Pulmonary Condition
- ❑ Unstable seizures
- ❑ Weight of 300 pounds
- ❑ Wound Dressing Changes
- ❑ Other (please indicate)

  _____

Medical Condition is:

- ❑ Temporary
- ❑ Permanent

If temporary, condition related to

- ❑ Surgery
- ❑ Accidents or Injury
- ❑ Pregnancy

Are you dependent on any of the following:

- ❑ Apnea Monitor
- ❑ CPAP
- ❑ Dialysis
- ❑ Electricity – Intermittent
- ❑ Electricity – Continuous
- ❑ Oxygen Hours Daily_____
  - ❑ Portable Tank ❑ Concentrator
- ❑ Nebulizer
- ❑ Special Diet
- ❑ Ventilator
- ❑ Pacemaker or Related
- ❑ Prescription Meds

Other Medical Equipment (please specify)

_____

Mobility

Ambulatory (can you get around) by yourself	❑ Yes	❑ No	Ambulatory with assistance	❑ Yes	❑ No
Can you climb stairs	❑ Yes	❑ No	Are you confined to a bed	❑ Yes	❑ No
Motorized scooter/Wheelchair	❑ Yes	❑ No	Wheelchair (non-motorized)	❑ Yes	❑ No
Can you independently transfer to/from a wheelchair	❑ Yes	❑ No	Do you need a wheelchair lift/ramp	❑ Yes	❑ No
Walker	❑ Yes	❑ No	Crutches	❑ Yes	❑ No
Cane	❑ Yes	❑ No	White Cane	❑ Yes	❑ No

Service Animals and Pets	
Do you have a service animal ❑ Yes ❑ No	Service Animal Weight in Pounds
Do you have other pets ❑ Yes ❑ No Cats _____ Dogs_____ Other (types of pets and number) _____	Do you have a pet emergency plan ❑ Yes ❑ No

Emergency Contact Information	
Name	Day Phone
Address	Evening Phone
Relationship to You	Cell Phone
Email	

Care Giver Information	
Care Giver Name	Care Giver Day Phone #
Care Giver Address	Care Giver Evening Phone #
Care Giver Relationship	Care Giver Cell Phone #
Email	
Will Care Giver accompany you to a Shelter ❑ Yes ❑ No	

Medical Provider Information	
Physician Name	Office Phone
Physician Office Address	
Physician Name	Office Phone
Physician Office Address	
Physician Name	Office Phone
Physician Office Address	

Dialysis or Other Similar Medical Treatment Center	
Name of Facility	Day Phone
Address	Evening Phone
Contact Person	
Medical Equipment Provider	
Name	Day Phone
Address	Evening Phone
Contact Person	
Home Health/Hospice Care Provider	
Home Health/Hospice Name	Day Phone
Address	Evening Phone
Contact Person	
Pharmacy	
Pharmacy Name	Day Phone
Address	Evening Phone
Pharmacist	

List of medicines

Prescription	Dosage	Schedule

Transportation	
Can you, a family member, friend or care giver provide you with transportation to a shelter in an emergency ❑ Yes ❑ No	If you need assistance with transportation, check one of the following ❑ Automobile ❑ Van with wheelchair lift ❑ Bus ❑ Medical transport required
Additional Comments	

By signing this form, I (or my legal guardian) agree that my name be added to the Flathead County Functional Needs Registry. I give Flathead County authorization to share this information with other community emergency responders only in the event of an emergency in order to facilitate an effective response. I grant emergency responders permission to enter my home following an emergency event or disaster situation, if necessary, to assure my safety and welfare.

Registrant Signature	Date
Authorized Legal Guardian Signature	Date

Mail completed form to:

Jennifer Rankosky
Flathead City County Health Department
1035 1st Avenue West
Kalispell MT 59901
751-8128
jrankosky@flathead.mt.gov

Or

Cindy Mullaney
Flathead County Office of Emergency Services
625 Timberwolf Parkway
Kalispell MT 59901
758-5504
cindy.mullaney@flatheadoes.mt.gov